Print Form

Member cancellation of coverage form

KAISER PERMANENTE®

Please print or type in black or blue ink only.

Company name

/ / Effective date of cancellation *(last day of month)*

Group no.

Medical subgroup no.

Dental subgroup no.

Name of subscriber *(last, first, MI)*

Health record no.

CANCELLATION FOR *(check one)*:

☐ Subscriber and dependents ☐ Medical ☐ Dental

☐ Dependent(s) only ☐ Medical ☐ Dental

If canceling dependents only, please list names and health record numbers of dependents to be cancelled:

Name of dependent *(last, first, MI)*

Health record no.

Name of dependent *(last, first, MI)*

Health record no.

Name of dependent *(last, first, MI)*

Health record no.

REASON FOR CANCELLATION *(check one)*:

Date *(MM/DD/YY)*

☐ Group coverage through spouse

☐ Cannot afford

☐ Divorce

☐ Deceased

☐ Termination of employment

☐ Other

By canceling group coverage, I understand that neither I nor my dependents can reenroll on this group policy until the next open enrollment period or a qualifying event.

Employee/subscriber signature

/ / Date

☐ Check if form completed by employer

Employer contact name

Date

Submission of form: Fax: 1-866-311-5974 Email: csc-den-roc-group@kp.org